

# Sonata.

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## Aesthetic Client Questionnaire

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

We are **so happy** that you are here! How did you hear about our office? \_\_\_\_\_

Is it ok for us to contact you to check in by phone? Y N By email? Y N By text? Y N

We often send thank yous, Is it ok for us to contact you by postal mail? Y N

Current Medications/Supplements \_\_\_\_\_

Latex Allergy? Y N Are you Pregnant? Y N Are you breastfeeding? Y N

Are you currently using Retin-A? Y N Are you currently using Latisse? Y N

We sometimes use aromatherapy in our treatments. Do you have any sensitivities to certain smells? Y N If yes, what scents? \_\_\_\_\_

Have you ever had a facial? Y N Have you ever had a chemical peel? Y N

Have you ever received Botox/Dysport or Fillers? Y N If yes, how recently? \_\_\_\_\_  
What is your current skin care regimen?

AM: \_\_\_\_\_

PM: \_\_\_\_\_

What skin care products do you regularly use? \_\_\_\_\_

How would you describe your skin? (circle as many as apply)

Aging Sensitive Dry Thin Oily Combination Acne-Prone Firm  
Sagging Sun-Damaged Other: \_\_\_\_\_

Do you have any medication allergies? \_\_\_\_\_

Do you tan or spend significant amounts of time outdoors in the sun? Y N

Do you smoke tobacco products? Y N

Would you say that you "bruise easily"? Y N

Which (if any) of these statements apply to you?

- I would prefer a longer-lasting result (2-4 years), even if it costs more
- I would prefer a longer-lasting result, even if it involves more recovery
- I would prefer a longer-lasting result, even if it is more invasive

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- I would prefer minimal recovery, even if it means a more temporary result (weeks to months)
- I would prefer minimal recovery, even if it means more modest improvement

**Body Dysmorphia Screening:** *It is our ethical responsibility to encourage you to have a healthy relationship with your body. Aesthetic treatments are imperfect and cannot help you solve life's more complicated problems. These questions help us serve and protect you best.*

- Approximately how many times a day do you deliberately check on your appearance (in a mirror, a reflective surface, on your phone, etc.)?  
\_\_\_\_\_
- To what extent do you feel your features are ugly, unattractive, or “not right”?  
\_\_\_\_\_
- Does your appearance cause you distress? \_\_\_\_\_
- Does your appearance cause you to avoid certain situations? \_\_\_\_\_
- On a scale of 1 to 10, how preoccupied with your appearance are you? \_\_\_\_\_
- On a scale of 1 to 10, how much does your appearance define you as a person?  
\_\_\_\_\_

If you are interested in Body Contouring, what areas of your body are you interested in improving/contouring?  
\_\_\_\_\_

What questions can I answer for you about skin care or your skin in general?  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to improve about your skin? (today or in the future)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Brown Spots/Sun Damage      | <input type="checkbox"/> Capillaries/Veins on face | <input type="checkbox"/> Drooping Mouth Corners        |
| <input type="checkbox"/> Dark Circles Under Eyes     | <input type="checkbox"/> Rough Skin Texture        | <input type="checkbox"/> Lines and Wrinkles/Upper Face |
| <input type="checkbox"/> Lines & Wrinkles/Lower Face | <input type="checkbox"/> Loss of Lip Volume        | <input type="checkbox"/> Loss of Cheek Volume          |
| <input type="checkbox"/> Jowls/Jawline laxity        | <input type="checkbox"/> Loose Skin On Neck        | <input type="checkbox"/> Acne Scars                    |
| <input type="checkbox"/> Deep Nasolabial Folds       | <input type="checkbox"/> Smoker's Lines            | <input type="checkbox"/> Sun Damage on Neck/Chest      |
| <input type="checkbox"/> Sun Damage on Hands         | <input type="checkbox"/> Sagging Eyelids           | <input type="checkbox"/> Large Pores                   |
| <input type="checkbox"/> Loss of Brow Height         | <input type="checkbox"/> Crepey Skin Under Eyes    | <input type="checkbox"/> Cellulite                     |

What else would you like me to know so that I can serve you best? \_\_\_\_\_  
\_\_\_\_\_

*Our Mission at Sonata is to bring beauty, love, light and compassion to our amazing patients.*